Report on Medicaid Reform Activities
Prepared by Richard P. Nelson, Director
Department of Health and Human Services Finance and Support
October 2005

Additional Considerations in Medicaid Reform

Public Policy Issues

The designees' September report included a request for public input on the content of a state public policy on Medicaid. LB 709 called for a comprehensive reform that would moderate the growth of Medicaid spending, ensure the future sustainability of the program, establish priorities and ensure flexibility in the allocation of benefits, and provide alternatives to Medicaid eligibility.

What do Nebraskans believe the purpose of the Medicaid program should be? Who should be eligible? What services should be covered? How do we correlate the answers to those questions with the goals of moderating the growth of Medicaid spending and ensuring future sustainability?

In the past 20 years, Medicaid spending has grown at an annual rate of nearly 11% while state revenues increased at an annual rate of about 7%. In the past 5 years, Medicaid spending grew at an average rate of about 7%, but state revenue growth dropped to about 3.5%. Spending growth that continues to exceed revenue growth does threaten the future sustainability of the program. In FY 2005, Budget Programs 348 (Medicaid) and 344 (Children's Health Insurance Program) constituted 17.2% of state General Fund spending. If General Fund spending for Medicaid in Budget Programs 38 (Behavioral Health Aid), 365 (Regional Centers), 421 (Beatrice State Developmental Center) and 424 (Developmental Disabilities) are included, the state General Fund spending for Medicaid was 20.2%. How should spending growth be controlled and what spending level is sustainable?

Medicaid eligibility focuses on four categories of low-income persons: children and pregnant women, low income caretaker relatives of the children, persons with disabilities, and the aged. Nebraska covers all mandatory income levels of these populations. It also provides optional Medically Needy coverage for low-income caretakers, aged, and persons with disabilities. It provides optional CHIP coverage for children to 185% of poverty. It also covers two other optional populations: a cervical and breast cancer program for women to 225% of poverty and a working disabled buy-in program for persons with disabilities to 250% of poverty. Finally, for Medicare-eligible persons for whom it must pay the Medicare monthly premiums, it also includes eligibility for Medicaid services to 125% of poverty. Who should be covered that is not currently covered? Who should not be covered that is currently covered?

Under federal law, any person who is eligible for Medicaid, whether under federal mandatory eligibility or state optional eligibility is entitled to receive every medical service offered by Medicaid in the state if it is medically necessary. The state must offer the federally mandatory services and can choose to offer a number of optional services. Optional services currently account for about 35% of Nebraska's Medicaid expenditures.

Under federal law, Medicaid is an entitlement program. The state must offer every service it covers to every eligible person statewide, any willing provider is entitled to participate in the program, and every eligible person is entitled to choose their provider. These

requirements can be changed only when the state applies for and the Centers for Medicare and Medicaid Services (CMS) grants a waiver.

The state has a managed care waiver that allows it to require eligible persons to select from an approved list of providers and allows the managed care company to determine which provider it will approve. The state also has waivers that allow it to control the number of persons receiving non-medical services for the aged and disabled and for persons with developmental disabilities. Does Nebraska want its state law to also create legally enforceable entitlements? Should the state make greater use of waivers that allow us to restrict the number of people using services, restricting the participation of providers, or restricting the services offered?

Under federal law, Medicaid's ability to impose cost sharing on Medicaid-eligible persons is very limited, e.g., co-payment amounts cannot exceed $3 per visit. In addition, Medicaid cannot refuse to pay for a service because the eligible person does not pay the co-pay. Should Nebraska expect some Medicaid-eligible persons to shoulder greater financial responsibilities for their services through various cost-sharing devices such as co-pays to the provider or buy-ins (premiums) to Medicaid? Is there an income level or other criteria, below which cost sharing is inappropriate state policy?

In Nebraska, the vast majority of Medicaid services are provided through the traditional medical service network of institutions and providers. There are alternative methods of delivery including Federally Qualified Health Centers and rural health centers. These programs serve both Medicaid and non-Medicaid clientele, including some uninsured persons. Nebraska has only 5 FQHCs and 111 rural health centers. Should Nebraska encourage or enable greater use of alternative delivery methods?

Most Nebraskans finance their access to health care through private health insurance, most of which is through employer-sponsored plans. Through the combination of Medicaid, Medicare, and private health insurance, about 11 % of the population are uninsured. The vast majority of Nebraska employers are small businesses, many of whom do not offer health insurance programs. Some large employers do not provide health plans to all of their employees. As costs of private health insurance rise, more of the costs are being shifted from the employer to the employee. The average employee's share of health insurance premiums is higher in Nebraska than the national average. What should the role of private health insurance be? What role, if any, should the state play in requiring, encouraging, or financing private health plans?

Individuals can do a great deal to maintain or improve their own health condition through healthy diet, regular exercise, maintaining a smoke-free home, and following good prevention measures. What responsibility should people who rely on public financing of health services have for controllable health conditions? What role should the state have in encouraging or providing health education and preventative health services?

Growth Projections for 2005 Nebraska Medicaid Reform Project

Background

True Medicaid reform does not consider only the current size and spending of the program, but also how that program will grow and change over time. Attachment 1 is an analysis of the potential growth of Medicaid. What follows is a brief explanation of the methodology employed and the results it produced.

The growth projection forecast provides the base line for estimating the future expenditures for the Nebraska Medicaid program if there are no substantial adjustments to the program (*such as changes in eligibility, changes in program benefits or additional programs*.)

The expenditure forecast will also serve as the basis for sensitivity analysis as the options for reform are being evaluated within each of the Medicaid Reform workgroups.

Developing the expenditure forecast required the development of units (eligibles) and costs (cost per eligible per month) and utilized data from several sources.

UNIT Development (Those eligible to receive Medicaid services.)

The first step was to develop a unit projection that would model the population specific to the State of Nebraska and adequately reflect the population shifts specific to our state.

- The Medicaid Population was split into the four distinct eligibility groups.
- The Nebraska population forecast by age was developed by Jerry Deichert, Director and Senior Research Associate with the Center of Public Affairs Research at the University of Nebraska at Omaha. This forecast was used to estimate growth in Medicaid Eligibles for the forecast period.
- The Nebraska population forecast contained the needed projections of total population and included adjustments for deaths, births and net migration based on historical information.
- The next step was to determine the projected number of Medicaid Eligibles using the total state population forecast and other knowledge and known facts.

The methodology assumed:

- The ratio of the number of Medicaid Group eligibles to the respective age population group will remain constant throughout the forecast period. This methodology will reflect the changes in population demographics throughout the forecast period.

Costs (Medicaid costs by Medicaid Group by month)

The second step was to account for cost changes.

- The basis for the forecast of the Medicaid cost by Medicaid Group is the 2005 Average Monthly Cost per Eligible.
- A cost adjustment factor was developed based on blending the historical Nebraska Medicaid average cost change rate for 5 years and the national annual medical expenditure per capita

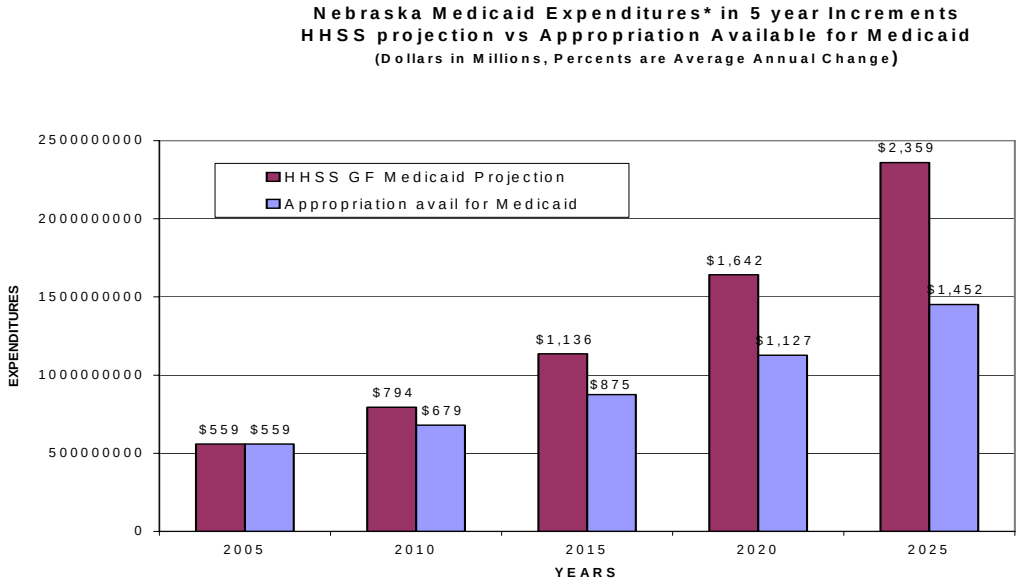
projections provided by CMS Office of the Actuary at the Centers for Medicare and Medicaid Services.

The methodology assumed:

- A blended cost adjustment factor would reflect the impact of 5 years of historical results specific to Nebraska by Medicaid Group and data based on CMS actuary projections for 2006-2014 of health care costs trends at the national level.
- The impact of the Medicare Prescription Drug Benefit changes, Drug Rebates and Premiums for Medicare Part B would not be included in the base expenditure forecast but added later as an adjustment.
- Changes in technology that would impact health care costs are included in historical data and no further adjustments have been included.

Expenditures of Annual Medicaid Costs by Medicaid Group

On the graph, the resulting forecast of General Fund Medicaid expenditures is compared



to the estimated Appropriation available for Medicaid.

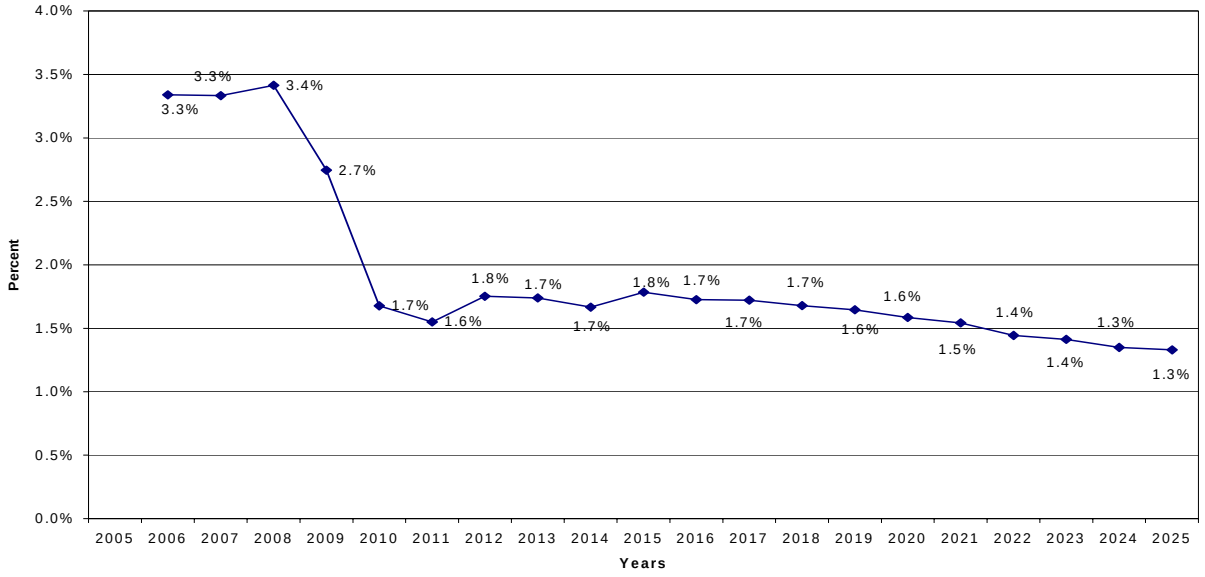
The state general fund revenue growth is calculated by projecting Medicaid's current share of General Fund as a constant percentage of the projected state general fund growth.

Variance	2005	2010	2015	2020	2025
In Millions	$0	$115	$261	$515	$907

By the year 2025, projected Medicaid growth would exceed available General Funds by $907 million. Matching Medicaid program growth to available General Fund dollars would require a

reduction of Medicaid expenditures in each year, from a high of 3.4% in FY2008 to a low of 1.3% in FY2025. On average, this would be an average annual reduction of 1.9%.

Nebraska Medicaid Expenditures 2005 to 2025
Additional Annual % Reduction to HHSS GF Medicaid Projection to maintain current ratio of Medicaid spending to projected state General Fund



Projected state General Fund growth rates for FY06-FY07 are based on forecasts from the Nebraska Forecasting Economic Advisory Board adjusted for bills passed during the 2005 Leg. Session. Growth rates for FY08-FY09 are based on forecasts from the Legislative Fiscal Office's estimate of GF net receipts. The remaining years are based on the historical average growth of appropriations using data from 1987 to 2007.

Every state's Medicaid program has been crafted according to the public policy of the state, the needs of its residents, and available financial resources. It is not surprising, therefore, that Medicaid reform is taking many different paths.

Attachment 2 is a compilation of reform plans from 14 states, selected to show the wide variety of proposals. Most of these proposals are very new and have no track record on which to evaluate them, although they may contain components that have track records, such as disease management or cost sharing. Many of the waiver requests are awaiting CMS approval before they can be implemented.

Selected Medicaid Issues

There are a number of Medicaid services and populations that compose a large share of Medicaid expenditures or that have grown rapidly in recent years. Any efforts to make Medicaid fiscally sustainable will likely need to focus on these areas.

Prescribed Drugs

Despite cost containment efforts in Nebraska that have slowed the growth of prescription drug expenditures, Medicaid expenditures on prescribed drugs nearly doubled over the past five years, from $124.3 million in SFY00 to $236.6 million in SFY05. Prescription drugs now comprise almost 17% of all Medicaid expenditures. (Medicaid over-the-counter drug expenditures increased from $3.3 million in SFY00 to $4.7 million in SFY05.) About 45% of the total expenditures on prescribed drugs were for the Adults with Disabilities population. The average expenditures per person in this category in SFY05 was $4,314, compared to average annual expenditures of $1,179 for all persons eligible for Medicaid.

It has been suggested that Nebraska adopt a formulary, establish a Preferred Drug List (PDL) and hopefully negotiate supplemental rebates. Another approach is to target particularly high cost drugs through prior authorization.

It is widely believe that psychotropic drugs are not appropriate for prior authorization or PDLs. Nearly 45 percent of all Medicaid prescription drug expenditures in SFY05 were for mental health drugs. Even after considering the impact of Medicare Part D coverage, which will begin on January 1, 2006, expenditures for psychotropic drugs will be substantial (at least $50 million in the current fiscal year) and afford an opportunity for significant cost savings to the Medicaid program.

One option for controlling expenditures on psychotropic medications is to replicate a program in Missouri that helps identify inefficient and ineffective prescribing patterns for Medicaid clients with mental health problems, based on evidence-based "best practice" standards for mental health drug therapy. Physicians who deviate from "best practices" are notified by letter and provided with information (in a non-threatening educational format) to help them make patient care decisions based on current medical evidence. This approach has resulted in changes in prescribing patterns in Missouri, and produced a cost savings of $7.7 million for the Missouri Medicaid program in SFY2004.

Expanding Home and Community Based Services, particularly for the aged

Long-term care services, including Home and Community Based (HCB) Services, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF-MR) accounted for almost one-third (32.7%) of Medicaid expenditures in SFY05. While 31.8% of Medicaid long-term care expenditures in SFY05 were on HCB services, up from 19.5% in SFY00, long-term care services for persons aged 65 and over are still heavily biased toward nursing facility care. Only 7.4% of long-term care expenditures in SFY05 on persons aged 65 and over were for HCB services, up from 5.1% in SFY00, but still significantly below the proportion of long-term care expenditures for adults with disabilities (54.7%).

Home and Community-Based Services can be expanded through waivers that allow the state to limit the number of people coming on to the program. Any expansion, however, raises issues that must be considered including quality of care, availability of services in rural areas, and staff in the Medicaid program sufficient to oversee the effective distribution of funds in multiple locations across the state.

Adults with Disabilities

The Adults with Disabilities population is the fastest growing Medicaid population and has the highest per person cost. The population increased 16.8% from SFY00 to SFY05, compared to a 9.8% increase for the total Medicaid population. While the adults with disabilities population comprised 12.2% of persons eligible for Medicaid in SFY05, the population accounted for 35.9% of Medicaid expenditures, making it the highest cost Medicaid population, with an average per person cost in SFY05 of $20,568 (compared to an average cost of $6,956 for all persons eligible for Medicaid).

Costs are particularly high for the top 10% of this population. Those receiving services on a fee-for-service basis have had no oversight or monitoring of the appropriateness and effectiveness of their care other than through the medical necessity requirement. Case management and, in the appropriate situation, disease management programs would increase administrative costs but may hold the promise of reducing expenditures through more effective utilization of services.

About 14 percent of persons in this category are currently receiving services through a Medicaid waiver. There are five separate waivers being used by this population: the Aged and Disabled waiver (accounting for almost 23% of the waiver population), three Adult Developmental Disabilities waivers (accounting for 77 percent of the waiver population), and a small Traumatic Brain Injury waiver. Through these waivers, Nebraska has been able to provide services, at a lower cost, to the disabled population in a community setting rather than in an institution. In order to receive waiver services, the individual must be eligible for ICF-MR services. In SFY05, the average Medicaid cost per person on an Adult Developmental Disabilities waiver was $46,210, compared to an average cost of $96,211 for persons in an Intermediate Care Facility for persons with Mental Retardation (ICF-MR). There may be additional persons who would qualify for and be appropriate for waiver services. The choice of whether to accept waiver services, however, rests with the eligible person or their responsible party. The General Funds to match the federal fund for Developmental Disability waivers is taken from the state aid program that also serves persons not eligible for the waiver.

Children with High Medical Costs

There is a small group of children in the Medicaid program, some with multiple disabling conditions that have very high medical costs. Some are being cared for in nursing facilities; some have a disability, and require acute-hospital level of services, but are being cared for at home with extensive supports provided through the Katie Beckett waiver. Other children with high medical costs have disabilities but have not yet been deemed disabled through the formal disabilities determination process. Only a few of these children currently have case management services available. A Medically Fragile Children's waiver may be available to place all of these high needs children in a case management program, possibly with disease

management services where appropriate. Again, this would increase the administrative costs of the program with a view toward reducing expenditures through more effective use of services.

Personal Responsibility:

- Making Healthy Choices

All persons have responsibility, to the extent that they are able, to make healthy lifestyle choices for themselves and their families. Public health studies clearly demonstrate that many illnesses result from making poor choices about diet, exercise, smoking and drinking. Sixty-one percent of Nebraska adults are considered overweight or obese. Smoking related health care costs in Nebraska are estimated at over $400 million a year. Smoking contributes to over 2,400 deaths a year in Nebraska, from cancer, cardiovascular disease and respiratory disease. Many of these illnesses can be prevented by the adoption of healthier lifestyles. The challenge is to find ways to encourage or enable the population to live a healthier life style. It would translate into reduced health costs for all citizens, not just Medicaid eligible people.

- Cost-sharing

Nebraska residents who purchase their own health insurance share the costs of care (in addition to premium payments) through co-payments and deductibles. For the standard Medicaid population, co-payments are very limited and, because Medicaid cannot deny services to someone who refuses to make their co-payment, they are not enforceable. Persons in the Children's Health Insurance Program can be asked to make higher co-payments. Through waivers, some states are seeking to increase the level of cost sharing for some part of the Medicaid population. This can be done through co-payments or through buy-in, in which the eligible person pays a premium to the Medicaid program. There is considerable debate around the question of whether cost sharing results in more appropriate utilization of services or simply denial of access. There is also debate around the question of whether there is an income level (percentage of federal poverty) below which cost sharing is inappropriate.

A different issue is presented by several Medicaid programs, including the children's waivers, under which the parents' income is not counted in determining Medicaid eligibility. It may be appropriate to consider parental contributions to care on a sliding scale basis, starting at a reasonable level of income.

Community Health Centers/Federally Qualified Health Centers

Access to quality health care services remains an issue, especially for those without health insurance. In addition, some Medicaid eligible persons make use of high cost services such as emergency rooms when it is not medically necessary. Community health centers have been shown to improve access to health care for some populations. They can often provide preventative or early diagnoses that avoid more costly health care later. Local health departments can be the sites of community health centers, although others can operate them as well. Federally Qualified Health Centers can receive some funding from the federal government. They also need to develop other funding sources, of which Medicaid can be one. FQHCs are required by federal law to provide services to anyone seeking them even though they have an

ability to pay. In those cases, a fee can be charged on a sliding scale basis. Medicaid must reimburse FQHCs on a cost basis. Some studies suggest that even if the community health center cost is higher, the overall cost for the patient is lower because they have received the preventative and early diagnosis services.

Medicaid Funding Strategies--Leveraging Federal Funds

Funding strategies Nebraska has utilized to maximize federal funds include intergovernmental transfers (IGT), provider taxes, certified public expenditures (CPE), and certain disproportionate share hospital payments (DSH). These strategies, which are regulated by CMS, rely on sources other than a direct state general fund appropriation to the Medicaid Program to satisfy the required non-federal share of the Medicaid match.

IGTs involve the transfer of funds from one level of government to another. The best-known use of this tool in Nebraska has been the nursing facility intergovernmental transfer arrangement through which HHSS claimed the maximum nursing facility payment allowable under federal regulations and participating nursing facilities then returned to the State the amount in excess of their established Medicaid per diem rates. Over $300 million in federal funds leveraged through this IGT have been held in trust and used at the Legislature's direction for a number of health-related projects. Capital grants for conversion of nursing facilities beds to assisted living, adult day care, and respite care were financed through this mechanism. CMS was originally a strong supporter of this IGT program, but it has recently withdrawn its endorsement of these kinds of arrangements. Nebraska, along with many other states, is now phasing out its operation.

Provider taxes involve the levying of a state tax on an entire category of health care providers as a method to generate revenue. The tax must be applied uniformly to all providers in the category, but providers may be reimbursed for the portion of the tax allocated to Medicaid clients if their reimbursement is cost-based. Nebraska currently applies a 6% net revenue tax to ICF/MR providers, whose clients are largely Medicaid eligible. The Medicaid-related portion of the tax expense is paid back to the facilities as an allowable cost of doing business and the reimbursement of this expense draws 60% federal funding. A portion of the tax proceeds are then freed up for other funding uses. Nebraska's tax generates $3.5 million in tax revenue annually. The Legislature directed that the net proceeds of the tax (after the Medicaid share of the tax expense has been paid back to the providers) be used to support increased payments to non-state-operated ICF/MR providers and to community-based service programs for persons with developmental disabilities. An additional $1.4 million of the revenue earned is transferred to the State General Fund. The Legislature previously authorized a provider tax on managed care providers, but because Nebraska lacks a broad based industry to tax, it has not been able to meet the requirements for implementation. CMS established a 6% maximum on provider tax arrangements, and a number of states have used this mechanism. As a part of federal Medicaid reform, the federal administration has proposed lowering this maximum to 3%. Therefore, the implementation of new provider taxes, in excess of 3%, run the risk of disapproval or being short-lived.

Certified public expenditures (CPE) use public funds provided through a public entity other than the Medicaid agency to satisfy state (non-federal) matching requirements to leverage federal funds. Other state agencies or local public entities incur a Medicaid-eligible expense and provide the public funds for the required non-federal match. The Medicaid Agency then includes the expense on federal claims and passes the federal matching share through to the certifying entity. Nebraska has utilized this mechanism to provide federal fund support for Medicaid-related activities carried out at the local level (e.g., public health nurses in local health departments, Medicaid services provided in public schools, and city or county-owned nursing facilities serving Medicaid residents).

CPE also is used to pull in federal funding for state obligations that would otherwise be financed primarily with state dollars. The Behavioral Health Reform project has minimized the need for additional state funding by substituting Medicaid-eligible community-based services for state regional center institutional care which qualifies for very limited Medicaid funding. This strategy allows the State to provide a wider variety of less expensive services with a constant level of appropriated general funds. Developmental disability services funded with only state general funds have also been moved to Medicaid-eligible community services. Together with increased state general fund appropriations over a period of years, the leveraging of federal Medicaid matching funds have enabled the state to serve a larger population of persons with developmental disabilities than would have been possible with state funding alone.

Additionally, when faced with the need to eliminate direct and indirect medical education payments to teaching hospitals, HHSS worked with major teaching hospitals to explore alternatives to elimination of these payments. As a result of this collaboration, HHSS implemented a Disproportionate Share Hospital (DSH) plan and regulation change that approximated the increased DSH allotment to the University teaching hospital. Disproportionate Share Hospitals serve a relatively high level of Medicaid and low-income patients and are eligible for supplemental federal funding. Approximately $7.8 million of additional DSH funding is channeled to the hospital. The additional revenue is sufficient to allow the State of Nebraska to continue funding the state portion of Direct and Indirect Medical education payments.

Financing strategies that can provide additional federal funding without increasing state general fund appropriations will continue to be explored. Any new effort must be approached with caution, however, because of efforts at the federal level to reduce or eliminate states' uses of these strategies.

Comparison of the Nebraska Medicaid Program to Other States' Medicaid Programs and to the Basic Nebraska State Employee Health Insurance Plan

Because of the latitude given to states to design their own Medicaid programs, no two state Medicaid programs are identical. States have some latitude in determining income levels for eligibility, and in deciding which optional services will be covered in their Medicaid program and which optional eligibility categories will be included. For this reason, state-to-state comparisons must be done with a great deal of caution. Nonetheless, it may be helpful to look at data for other states to provide some context for understanding Nebraska's Medicaid program.

As mentioned earlier, states have some latitude in determining income levels for eligibility. These income levels are determined in relation to the Federal Poverty Level (FPL), which varies by family size. Table 1 shows the income eligibility levels for different Medicaid populations for Nebraska and surrounding states. For some populations, Nebraska's eligibility rules are more generous than those of surrounding states; for other populations, Nebraska's eligibility rules are less generous than surrounding states. For all populations, however, the income eligibility levels for Nebraska fall within the range of levels for surrounding states.

Table 1
Medicaid Income Eligibility as a Percent of Federal Poverty Level
2004

	Medicaid			Pregnant Women	Non-Working Parents	Working Parents
	Infants < 1 Year	Children Ages 1-5	Children Ages 6-19			
NE	185%	185%	185%	185%	48%	56%
CO	133%	133%	100%	185%	32%	39%
IA*	200%	133%	133%	200%	33%	82%
KS*	150%	133%	100%	150%	31%	38%
MO	300%	300%	300%	185%	75%	82%
SD	140%	140%	140%	133%	61%	61%
WY	133%	133%	100%	133%	45%	60%

* Iowa and Kansas offer stand-alone CHIP programs with eligibility to 200% FPL.
Source: Kaiser Family Foundation

Another available comparison is in the number of persons eligible for Medicaid in each state, and the average Medicaid expenditure per eligible person. These data are provided in Table 2 for 46 of the 50 states and the District of Columbia. In the most recent year for which these data are available (Federal Fiscal Year 2003 (FFY03)), Nebraska ranked 18th among the 46 reporting states in the average cost per eligible person ($4,762.05). This is slightly above the national average of $4,592.40. Since the older adult population is one of the most expensive Medicaid

populations, a likely explanation for the difference between the Nebraska average cost and the national average cost is the difference in the proportion of the population that is aged 65 and older; in Nebraska, 13.6% of the population is aged 65 and older, compared to the national average of 12.4%.

During FFY03, 269,331 persons in Nebraska were eligible for Medicaid. This represents 15.5% of the state's population, compared to the national average of 18.1%.

Table 2
Medicaid Expenditures and Unduplicated Annual Eligibles/Recipients by State
Federal Fiscal Year 2003

	Cost Per Eligible	Unduplicated Annual Eligibiles	Unduplicated Annual Recipients	Expenditures
New York	$7,681.43	4,583,362	4,449,939	$35,206,760,472
District of Columbia	$7,637.36	157,101	158,179	$1,199,837,436
Connecticut	$6,688.69	502,265	496,680	$3,359,497,127
Alaska	$6,600.32	126,587	116,211	$835,515,131
Minnesota	$6,438.84	730,195	667,500	$4,701,612,364
Rhode Island	$6,338.15	211,136	201,875	$1,338,212,632
New Jersey	$6,186.74	974,601	949,741	$6,029,601,253
North Dakota	$5,801.00	76,677	76,754	$444,803,367
Maine	$5,482.41	378,346	307,279	$2,074,246,677
Massachusetts	$5,355.51	1,193,533	1,042,123	$6,391,977,781
Pennsylvania	$5,288.03	1,787,059	1,721,707	$9,450,026,724
Ohio	$5,279.20	1,938,785	1,778,325	$10,235,239,405
Iowa	$5,271.10	378,708	361,760	$1,996,207,221
West Virginia	$4,989.18	366,787	373,154	$1,829,967,627
Kansas	$4,965.74	325,177	316,411	$1,614,744,381
Montana	$4,851.90	110,549	110,403	$536,372,686
Colorado	$4,787.70	473,880	459,207	$2,268,794,322
Delaware	$4,787.18	156,721	149,864	$750,252,370
Nebraska	**$4,762.05**	**269,331**	**253,728**	**$1,282,568,106**
South Dakota	$4,527.50	119,693	123,590	$541,910,489
North Carolina	$4,496.76	1,450,218	1,416,912	$6,521,288,060
Kentucky	$4,391.51	810,159	847,943	$3,557,820,183
Wisconsin	$4,338.26	903,902	829,287	$3,921,363,613
Virginia	$4,318.05	736,672	709,488	$3,180,990,089
Utah	$4,315.78	278,232	285,370	$1,200,789,487
Illinois	$4,312.46	2,177,724	1,830,233	$9,391,357,857
Wyoming	$4,227.73	76,786	66,605	$324,630,777
Indiana	$4,179.56	945,267	895,973	$3,950,802,203
Idaho	$4,154.10	208,748	193,302	$867,160,476
New Mexico	$4,126.11	492,830	452,120	$2,033,470,195

Michigan	$4,120.59	1,572,356	1,589,501	$6,479,029,763
Florida	$3,908.20	2,841,305	2,743,368	$11,104,376,050
Washington	$3,897.96	1,160,614	1,077,070	$4,524,032,645
Alabama	$3,886.76	893,115	780,617	$3,471,319,724
Missouri	$3,808.10	1,157,231	1,081,496	$4,406,852,103
Nevada	$3,731.08	236,211	220,417	$881,323,024
South Carolina	$3,670.75	992,090	861,216	$3,641,714,949
Hawaii	$3,582.04	420,690	417,970	$1,506,926,856
Mississippi	$3,515.45	730,995	717,435	$2,569,776,154
Louisiana	$3,428.23	1,054,455	995,362	$3,614,909,979
Texas	$3,420.92	3,661,162	3,339,796	$12,524,526,333
Oregon	$3,381.17	625,704	598,110	$2,115,608,505
Tennessee	$3,305.69	1,651,486	1,729,589	$5,459,293,763
Arkansas	$3,274.29	675,552	702,064	$2,211,952,987
Oklahoma	$3,193.45	666,529	625,875	$2,128,524,455
California	$2,569.05	10,047,498	9,319,148	$25,812,495,569
Arizona	$2,568.91	1,278,894	1,014,813	$3,285,364,385
All States	$4,592.40	52,606,918	49,455,510	$222,775,847,755
Source: MSIS FFY2003 Quarterly Data Cube				

Comparison of the Nebraska Medicaid Program to Nebraska State Employee Health Insurance Coverage

To examine the appropriateness of services covered under the current Medicaid program in Nebraska, HHSS completed a comparative analysis of the Medicaid program and the basic health, dental, and vision coverage available to Nebraska State employees. One area of difference is in the co-payment requirements. Under the Blue Cross/Blue Shield plans, many services require a co-pay (e.g., $11 for generic drugs; $15 for in-network office visits, routine physicals, maternity visits, well baby care and annual exams for women; $27 for brand name drugs; and $50 for an outpatient surgery center.) Federal law establishes Medicaid co-pay limits. For many services, there is no Medicaid co-pay requirement. Other services, like physician office visits and prescribed drugs require a $2 co-pay. However, Medicaid recipients cannot be denied services if they are unable to meet the co-payment requirement.

The analysis revealed that, with the following exceptions, Medicaid covered services do not differ appreciably from the State employees basic Blue Cross/Blue Shield and optional dental and vision coverage plans:

- Long-Term Care Services. Traditional health insurance policies do not cover long-term nursing facility or similar care.

- Waiver Services. Waiver services are non-medical services provided to an individual as a cost-effective alternative to nursing facility care. The availability of waiver services often allows

an individual to remain in the community, often in their own home, preventing the need for more expensive nursing facility care. Traditional health insurance plans do not cover waiver services, although many insurance providers recognize the cost-effectiveness of such services and are moving in this direction.

- Mental Health Services. Most health insurance policies have restrictions on mental health coverage. The basic State employees Blue Cross/Blue Shield plan has a 30-day calendar year limit on inpatient mental health services and a 60-visit calendar limit on outpatient mental health therapy (except in serious cases). Medicaid has no such limits.

- Service Caps. Traditional health insurance often places caps on the usage of other medical services, e.g., outpatient rehabilitation services.

- Services requiring prior authorization or pre-certification. Blue Cross/Blue Shield requires prior authorization or pre-certification for four types of service: mental illness and/or substance abuse treatment; physical rehabilitation; long-term acute care; and skilled nursing facility care. Medicaid requires prior authorization for many services.

Below is a detailed comparison to a basic insurance plan for state employees and Medicaid. In each paragraph, the report first explains what the basic state plan offers and then compares that to Medicaid. The first part compares Blue Cross Blue Shield to Medicaid. Then, there is a short comparison of drug coverage. An explanation of the differences in vision plans follows. Lastly, we look at a comparison of the state employee's basic dental plan and Medicaid.

Blue Cross Blue Shield Comparison

Blue Cross Blue Shield, BCBS, does not have a lifetime maximum for in-network doctors, but has a $2 million per person maximum for out-of-network doctors. There is no lifetime maximum for Medicaid.

BCBS does not have a calendar year deductible for in-network doctors, but has a $500/individual ($1,000/family maximum) for out-of-network doctors. There is no calendar year deductible for Medicaid.

For inpatient hospital and approved skilled nursing facility, BCBS requires 20% co-insurance for in-network providers and 40% for out-of-network providers. Medicaid does not have any co-pay for inpatient hospital and approved skilled nursing facility.

BCBS requires a $50 co-pay for outpatient surgery center (facility fee only) if the doctor is in their network. If the doctor is out-of-network, there is 40% co-insurance. Medicaid requires a $3 co-pay for these services.

For outpatient hospital services including diagnostic lab, x-ray, surgeries, etc., BCBS requires 20% co-insurance for in-network providers and 40% co-insurance for out-of-network providers. Medicaid requires a $3 co-pay per visit.

An independent diagnostic lab and x-ray does not require a co-pay for an in-network provider for BCBS, but for an out-of-network provider BCBS requires 40% co-insurance. Medicaid does not require a co-pay for these services.

Below is a table that explains the comparison between BCBS and Medicaid for physician office visits and preventative care services:

Service	In-Network Doctor	Out-of-Network Doctor	Medicaid
Office Visit	$15 co-pay	40% co-insurance	$2 co-pay for adults
Routine Physical	$15 co-pay	40% co-insurance	No co-pay
Annual Female Exam	$15 co-pay	40% co-insurance	No co-pay
Well Baby Care	$15 co-pay	40% co-insurance	No co-pay
Maternity Visits	$15 co-pay	40% co-insurance	No co-pay
Allergy Testing	No co-pay	40% co-insurance	No co-pay
Routine Immunizations	No co-pay	40% co-insurance	No co-pay
Surgery	No co-pay	40% co-insurance	$3 co-pay for adults
Radiology and Lab	No co-pay	40% co-insurance	No co-pay
Chemotherapy	No co-pay	40% co-insurance	No co-pay
All Other Physician Svc	No co-pay	40% co-insurance	$2 co-pay for adults

For an ambulance, there is no co-pay for BCBS or Medicaid. For urgi-center services, BCBS requires a $25 co-pay for in- and out-of-network doctors while Medicaid does not require a co-pay. BCBS requires a $50 co-pay for in- and out-of-network doctors for hospital emergency room services. Medicaid does not require a co-pay for hospital emergency room services.

For durable medical equipment, BCBS requires a 20% co-insurance for in- and out-of-network providers. Medicaid does not require a co-pay.

BCBS requires a $15 co-pay for an in-network provider for outpatient rehabilitation services and an out-of network provider would require 40% co-insurance. BCBS allows up to 60 visits per calendar year. Medicaid requires a $1 co-pay for such services and chiropractic care is limited to 20 treatments per year. Other treatments in this category do not have a limit of visits per year, but the services must be medically necessary.

For home health care and hospice services, BCBS does not require a co-pay for in-network providers, but requires 40% co-insurance for out-of-network providers. Medicaid does not require a co-pay for home health and hospice services.

BCBS does not require a co-pay for an in-network doctor for an organ transplant, but requires 40% co-insurance for an out-of-network doctor. Medicaid requires a $2 co-pay if the recipient sees a specialist. Otherwise there would not be a co-pay.

For inpatient mental health, BCBS requires 20% co-insurance for an in-network provider and 50% co-insurance for an out-of-network provider. Medicaid does not require a co-pay, but prior authorization through Magellan is necessary. BCBS only allows 30 days maximum per calendar year. Medicaid does not have a specific limitation beyond the required prior authorization.

For outpatient mental health therapy visits, BCBS requires a $20 co-pay for in-network providers and 50% co-insurance for out-of-network providers. Medicaid does not require a co-pay, but does require prior authorization through Magellan. In this same category, if there are

miscellaneous charges, BCBS requires 20% co-insurance for in-network providers and 50% co-insurance if the provider is out-of-network. BCBS only allows 60 visits per calendar year except in serious cases. Medicaid does not have a specific limitation beyond the required prior authorization for day treatment level of care and above.

The above descriptions have all been for services that both BCBS and Medicaid cover. Below are some services that Medicaid covers that BCBS does not:

- Hearing Aids – BCBS does not cover hearing aids or the fitting while Nebraska Medicaid covers hearing aids, hearing aid repairs, necessary batteries, and supplies with prior authorization.
- Nutrition Care – BCBS does not cover nutrition services while Nebraska Medicaid covers personal care aides who will assist with nutrition services. Nebraska Medicaid also covers medically necessary supplemental formulas and licensed medical nutritional therapists (LMNT) to children as a part of the mandatory under EPSDT services.
- Residential Treatment for Mental Health and Substance Abuse – BCBS will not cover residential treatment services for treatment of mental illness and/or substance abuse. Nebraska Medicaid covers medically necessary psychiatric services for those 21 years of age and older through outpatient services and day treatment. If the Medicaid eligible individual is 20 years old or younger, covered services include outpatient and day treatment services for mental health and substance abuse. Services include day treatment, foster care, group home, residential treatment, inpatient, and institutions for mental disease (IMDs).
- Organ Transplant Expenses – BCBS does not cover services related to lodging and/or transportation, and donor charges. Nebraska Medicaid may cover medical transplant expenses that have special requirements, limitations, and/or approval from Medicaid.
- Long-Term Care – BCBS only covers long-term acute care while Nebraska Medicaid also covers custodial services. The levels of care covered by Medicaid include nursing facilities, intermediate care facilities for person with mental retardation, and certain other long-term care living arrangements.
- Medical Transportation – BCBS does not cover medical transportation. Nebraska Medicaid covers transportation services for trips necessary to obtain medical treatment or medical care when the client has no other means of transportation. Medicaid may cover transportation services for a parent/caretaker/attendant for travel to escort someone to and from medical treatment or medical care when necessary and when there is no other means of transportation. Medicaid does not, however, cover transportation services for clients residing in nursing facilities. The facility is responsible for providing needed health care for its residents.

Other services that require prior authorization or pre-certification under Medicaid are:

- Acute Inpatient Rehabilitation Hospital Services
- All Medical Transplants
- EPSDT Special Needs Services (for services not otherwise covered)
- Out of State Services (excludes “border status” where client lives close to the Nebraska border and normally gets medical services just across the border in another state)
- Bariatric Surgery for Weight Loss
- Certain Plastic Surgery Procedures (to determine whether it is medically necessary)

- Certain Durable Medical Equipment (DME)
- Certain Dental Services
- Certain Specified Drugs in the Pharmacy Program
- Synagis (RSV Prevention Drug) in the Practitioner Program
- Mental Health Services (All levels of care including day treatment and above)
- Hospice Services
- Home Health Agency/Private Duty Nursing Services
- Personal Aid Services (at the local office)
- Lock In Clients – specified services
- Managed Care (many services require authorization)
- Medicaid Waiver Services
- Transportation Services (local office has to authorize care)

Services that require prior authorization or pre-certification under BCBS are:

- Mental Illness and/or Substance Abuse Treatment
- Physical Rehabilitation
- Long-Term Acute Care
- Skilled Nursing Facility Care

Drug Plan Comparison

The Walgreens Pharmacy basic plan requires an $11 co-pay for generic drugs and a $27 co-pay for brand name drugs. Medicaid requires a $2 co-pay for drugs for adults.

Vision Service Plan Comparison

The state employee's basic vision plan costs $12.10 per month for an employee and children. There is no monthly cost for Medicaid recipients.

The state employee's basic vision plan allows vision exams every 12 months. The co-pay for a network provider is $10 and an out-of-network provider could be up to $35. Medicaid allows vision exams for children every 12 months and adults every 24 months. There is no co-pay for children, but the adults pay a $2 co-pay.

The state employee's basic vision plan allows a participant to get new glasses, lenses, and frames every 24 months. There is a co-pay for lenses and frames of $10 each if you go to a network provider. For out-of-network providers, the co-pay for frames can be up to $35 and for lenses the co-pay can be up to $80 (single vision = $25, lined bifocal = $40, lined trifocal = $55, lenticular = $80). Medicaid allows for as many pairs of glasses as a child needs (no limit) and adults are allowed one replacement pair per year. Children under Medicaid do not pay a co-pay and adults must pay a $2 co-pay.

The state employee's basic vision plan allows for new contacts every 24 months. There is not a co-pay for a network provider, but if you go outside of your network the co-pay can be up to $105. Medicaid recipients are not automatically allowed to receive contacts. They have to provide proof that contacts are medically necessary. In Medicaid, replacement of contact lenses

is covered when required. There is no co-pay for children and a $2 co-pay for adults on Medicaid.

Dental Plan Comparison

The state employee's basic dental plan costs $57.62 per month for an employee and children. There is no monthly cost for Medicaid recipients.

Preventative Procedures:

The state employee's basic dental plan allows exams, cleanings, x-rays, and sealants twice a year. If the employee goes to a PPO dentist, the plan pays 100%. If the employee goes to a non-PPO dentist, the plan only pays 50%. There are no co-pays for any preventative procedures. Medicaid allows children to receive a dental exam, prophylaxis and x-rays every six months or more often if medically necessary if the treating dentist feels it is appropriate. Adults are allowed a dental exam once a year unless the adult qualifies as having special needs. Clients with special needs can be seen at the frequency recommended by their dentist.

(Examples of special needs that qualify a client for more frequent services are pregnancy, clients that are receiving treatment or medication that affects the condition of their mouth (dry mouth caused by chemotherapy or radiation treatment for cancer), or the client is unable to care for their mouth on their own because of a disability.)

Medicaid covers dental sealants when the treating dentist feels they are appropriate.

Basic Procedures:

The state employee's basic dental plan for fillings, root canals, gum disease, and extractions with a PPO dentist will pay 80% and with a non-PPO dentist will pay 50%. There is a $50 deductible per person and a $150 maximum deductible per family per year. Medicaid allows coverage for filings and extractions without prior authorization. Root canal procedures and treatment of gum disease (limited to periodontal scaling and root planing) require prior authorization and must meet policy coverage criteria. Children under Medicaid do not pay a co-payment, but adults must pay a $3 co-pay for root canal procedures.

Major Procedures:

The state employee's basic dental plan for initial and replacement crowns, dentures, and bridges with a PPO dentist will pay 50% and with a non-PPO dentist will pay 25%. Medicaid requires prior authorization for crowns. Crowns are allowed if the tooth can not be restored by any other treatment. Adults must pay a $3 co-pay for crowns. Dentures are allowed without prior authorization if they are immediate dentures or treatment dentures that are placed immediately following the extraction of the teeth. Replacement dentures and partials require prior authorization and adults must pay a $3 co-pay. Medicaid does not cover bridges.

For preventive, basic, and major procedures in the state employee's basic dental plan there is a maximum of $1,000 per person per year. Medicaid does not have an annual maximum.

Orthodontia & TMJ procedures:

The state employee's basic dental plan for orthodontia and TMJ procedures for children to age 19 for a PPO dentist will pay 50% and for a non-PPO dentist will pay 25%. There are no co-pays for these services. There is also a $2,000 lifetime maximum per person. Medicaid requires prior authorization for orthodontic treatment. Orthodontic treatment is allowed for children age 20 and younger if the case qualifies as medically necessary by program policy and is not allowed for adults. There is no lifetime maximum under Medicaid. Medicaid limits coverage of TMJ procedures to splints, which do not require prior authorization.

Attachment 1
Growth Projections
for 2005 Nebraska Medicaid Reform Project

Executive Summary

The Medicaid Expenditure Projections for Medicaid Reform were prepared by applying increases in projected Medicaid population and projected medical costs to total Medicaid expenditures by eligibility group.

The total population forecast was provided by Jerry Deichert from the Center of Public Affairs Research at the University of Nebraska at Omaha. Jerry Deichert is the director and senior research associate at the Center for Public Affairs Research (CPAR). The Center for Public Affairs Research is the lead agency for the Nebraska State Data Center program, which provides access to the information available from the U.S. Census Bureau. His areas of research include economic projections for the state and population projections for the state, counties and other sub-areas. Jerry Deichert is also the Manager of the Nebraska State Data Center.

The basis for the forecast of the Medicaid eligibles by Medicaid Group was the total Nebraska Medicaid eligibles multiplied by the percentage increase in the population projection of the like age group. Additional consideration was given to the impacts of changes in poverty level, migration specific to the disabled population and additional cost as the Adult disabled population ages into the Aged category. However, no adjustments were made for these potential impacts .

The basis for the forecast of the Medicaid cost by Medicaid Group by month is the 2005 Average Monthly Cost per Eligible. Cost adjustment factors were developed by Medicaid Group using a blending of historical Medicaid increases and national medical cost forecasts. The methodology provides consideration for the impact of technology changes in the costs of the Medicaid groups, to the extent they have been felt historically.

The resulting total eligibles were multiplied by projected costs per person to arrive at a total projected General Fund expenditure.

The impact of Medicare Part D changes, Drug Rebates and Premiums for Medicare Part B are not included in the base expenditure forecast results but may be added later as an adjustment.

Background

The base forecast for the Projections for 2005 Medicaid Reform was provided by Jerry Deichert from the Center of Public Affairs Research at the University of Nebraska at Omaha. Jerry Deichert is the director and senior research associate at the Center for Public Affairs Research (CPAR). The Center for Public Affairs Research is the lead agency for the Nebraska State Data Center program which provides access to the information available from the U.S. Census Bureau. His areas of research include economic projections for the state and population projections for the state, counties and other sub-areas. Jerry is also the Manager of the Nebraska State Data Center.

The base forecast contained projections of total population for men and women by single year age groups through 2030. The basis for the base forecast are numbers from the 2000 Census and include adjustments for deaths, births and net migration. The assumptions are:

- The aggregate net migration will be about 0, that is the number of people moving into the state will be similar to the number leaving the state. The specific rates by age are the same for men and women and are constant throughout the projection period. They are based on a weighted average of the rates of the 1980s and 1990s.
- The birth rates by age of mother were calculated for 2000 and adjusted to reflect the increasing births during the first 3 years of the 2000s and then held constant during the rest of the projection period. Survival rates are national survival rates and vary by gender. These rates change every year during the projection period.

Nebraska Population Forecast

	2005	2010	2015	2020	2025
Total Population:	1,762,961	1,818,531	1,877,193	1,934,948	1,990,775
Total 20 years and Under	527,200	533,275	546,179	567,826	583,911
Total 21 to 64 inclusive	999,260	1,035,793	1,049,315	1,040,568	1,031,625
Total 65 and over	236,501	249,463	281,699	326,554	375,239
5 year % Change:					
Total Population Change		3.15%	3.23%	3.08%	2.89%
Total 20 years and Under		1.15%	2.42%	3.96%	2.83%
Total 21 to 64 inclusive		3.66%	1.31%	-0.83%	-0.86%
Total 65 and over		5.48%	12.92%	15.92%	14.91%
Age Group Compared to total population					
% children	29.9%	29.3%	29.1%	29.3%	29.3%
% adult	56.7%	57.0%	55.9%	53.8%	51.8%
% aged	13.4%	13.7%	15.0%	16.9%	18.8%

The next step was to determine the number of Medicaid Eligibles using the base forecast of total population for the State of Nebraska and other knowledge and known facts. The goal was to develop a projection of units and costs which would extend to 2030 and serve as the basis for expenditure projections and possibly sensitivity analysis for the options being developed within each of the Medicaid Reform workgroups. There are no adjustments for birth/death rates specific to Nebraska specific data as these adjustments are already represented in the base forecast. There are no adjustments for changes in eligibility, changes in program benefits or additional programs.

Units (Medicaid Eligibles by Group)

Projections of the Medicaid Eligible Population per Medicaid Category per month

Years included 2005 to 2025

	Actual 2005	2010	2015	2020	2025
Aged (65+)	18,291	19,293	21,787	25,256	29,021
Blind	241	248	252	254	255
Disabled	28,483	29,278	29,771	30,012	30,145
ADC Adults	23,635	24,499	24,819	24,612	24,401
Children (20 and under)	128,107	129,583	132,719	137,979	141,887
Total Medicaid Eligibles	198,757	202,902	209,347	218,112	225,709

5 year % Change of Medicaid Eligible population per category	2010	2015	2020	2025
Aged (65+)	5.48%	12.92%	15.92%	14.91%
Blind	2.79%	1.68%	0.81%	0.44%
Disabled	2.79%	1.68%	0.81%	0.44%
ADC Adults	3.66%	1.31%	-0.83%	-0.86%
Children (20 and under)	1.15%	2.42%	3.96%	2.83%
Total Medicaid Eligibles	2.09%	3.18%	4.19%	3.48%

The base forecast of total population for the State of Nebraska is the starting point for determination of the respective Medicaid Groups of Aged, Blind/Disabled, Children and ADC Adults. The Medicaid Eligible populations were developed using 2005 actual information. A ratio was recreated by comparing the average monthly eligibles to the respective age groups within the total population; for example, Total Medicaid Eligible Aged to Total Aged population. The ratio was then applied to the base forecast of people 65+ on a year by year basis to determine the number of eligibles in each group during the forecast period. This methodology was applied to each of the Medicaid Groups.

Assumptions include:

- The ratio of the number of Medicaid Group eligibles to the respective age population group will remain constant throughout the forecast period. This methodology will reflect the changes in population demographics throughout the forecast period.
- The impact of the changes in the poverty level was considered, but no adjustments were included.
- The migration of disabled from other states was considered, but no data exist to estimate the potential impact.
- The migration of Adult Disabled to the Aged category was not adjusted due to the similar costs associated with each group.

Costs (Medicaid costs by Medicaid Group by month)

Projections of the Medicaid Cost per Medicaid Category per eligible per month

Years included 2005 to 2025

	Actual 2005	2010	2015	2020	2025
Aged (65+)	$ 1,662.90	$ 2,144.53	$ 2,742.42	$ 3,522.83	$ 4,525.32
Blind	$ 985.50	$ 1,112.33	$ 1,244.65	$ 1,399.16	$ 1,572.86
Disabled	$ 1,649.32	$ 2,307.45	$ 3,201.51	$ 4,461.70	$ 6,217.94
ADC Adults	$ 367.16	$ 533.86	$ 769.87	$ 1,115.11	$ 1,615.17
Children (20 and under)	$ 234.74	$ 333.08	$ 468.72	$ 662.51	$ 936.44

5 year % Change of Average Cost per eligible per category	2010	2015	2020	2025
Aged (65+)	29%	28%	28%	28%
Blind	13%	12%	12%	12%
Disabled	40%	39%	39%	39%
ADC Adults	45%	44%	45%	45%
Children (20 and under)	42%	41%	41%	41%

The basis for the forecast of the Medicaid cost by Medicaid Group by month is the 2005 Average Monthly Cost per Eligible. The cost adjustment factor was developed based on blending the historical Nebraska Medicaid average cost change rate for 5 years and the national annual medical expenditure per capita projections provided by CMS Office of the Actuary at the Centers for Medicare and Medicaid Services.

Assumptions include:

- The cost adjustment factor was developed to include the impact of 5 years of historical results specific to Nebraska by Medicaid Group and data based on CMS actuary projections for 2006-2014 of health care costs trends at the national level.
- The impact of Medicaid Part D changes, Drug Rebates and Premiums for Medicare Part B are not included in the base expenditure forecast results but added later as an adjustment.
- The changes in technology that would impact health care costs have been considered. The changes are included in historical data; no further adjustments have been included.

*Expenditures of Annual Medicaid Costs by Medicaid Group

Projections of the Medicaid Expenditure per Medicaid Category

Years included 2005 to 2025

	Actual 2005	2010	2015	2020	2025
Aged (65+)	$ 364,993,247	$ 496,505,299	$ 716,977,035	$ 1,067,658,383	$ 1,575,950,758
Blind	$ 2,850,066	$ 3,306,646	$ 3,762,313	$ 4,263,576	$ 4,814,154
Disabled	$ 563,730,979	$ 810,690,870	$ 1,143,750,383	$ 1,606,847,391	$ 2,249,287,336
ADC Adults	$ 104,133,919	$ 156,947,881	$ 229,287,491	$ 329,340,925	$ 472,931,068
Children (20 and under)	$ 360,862,046	$ 517,936,442	$ 746,492,366	$ 1,096,955,206	$ 1,594,422,895
Total Expenditure	$ 1,396,570,257	$ 1,985,387,138	$ 2,840,269,589	$ 4,105,065,480	$ 5,897,406,211
40% of Total Expenditure	$ 558,628,103	$ 794,154,855	$ 1,136,107,835	$ 1,642,026,192	$ 2,358,962,484

5 year % Change of Medicaid Expenditure per category	2010	2015	2020	2025
Aged (65+)	36%	44%	49%	48%
Blind	16%	14%	13%	13%
Disabled	44%	41%	40%	40%
ADC Adults	51%	46%	44%	44%
Children (20 and under)	44%	44%	47%	45%
Total Expenditure	42%	43%	45%	44%

Average Annual Percent Change

	2010	2015	2020	2025
HHSS ST Medicaid Expenditures	7.29%	7.42%	7.64%	7.51%
Appropriation Avail for Medicaid	3.98%	5.20%	5.20%	5.20%

*Expenditure net of other adjustments (Part B Premiums, drug rebates, etc.)